McLaren Business Products

McLaren Print System Order

Order No: 75027 Reprint Previous Order No: 75015
Order Date: 2023-02-01
User: Angie Claerhout
Phone: 9896673420

Ship Location: Bay Orthopedic Surgery
4 Columbus Ave Suite 160
Bay City, Michigan 48708
Forms
Quantity: 100
Paragon Dept No: 51535
Dept Name: McLaren Bay Orthopedic Surgery
Company Number: 210

Order Total Price: 0.00

Item Number: B-140
Item Description: Referral Form Bay Orthopedic Surgery
Revision Date: 01/23
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: 8.5x11 black

McLaren
BAY REGION
ORTHOPEDIC SURGERY
4 Columbus Ave., Ste. 160
Bay City, MI 48706
Phone: (989) 393-2777 • FAX: (989) 894-6181

Referring Office to Complete and FAX to (989) 894-6181
PHYSICIAN REFERENCE
DR. RENDER DR. O'JOHN

Today's Date: _____
Patient Name: _____ D.O.B.: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell/Work: _____ Email Address: _____
Referring Physician: _____ Phone: _____ FAX: _____
Reason for Referral: _____
Is this a result of: Injury? ☐ Yes ☐ No Date of Injury or Onset of:
Car Accident? ☐ Yes ☐ No _____
Work Accident? ☐ Yes ☐ No (Month / Day / Year required)
Other Accident? _____
Family Physician? _____ Phone: _____ FAX: _____
Primary Insurance: _____ Subscriber: _____ D.O.B.: _____
Patient ID#: _____ GRP#: _____ Effective Date: _____
Secondary Insurance: _____ Subscriber: _____ D.O.B.: _____
Patient ID#: _____ GRP#: _____ Effective Date: _____

Please FAX this form back to us with labs, tests, notes, including other physician's notes, records, and any information pertaining to this referral. Please include all insurance information and prior authorization that may be required. We will review all information prior to contacting the patient with a scheduled appointment.

1. Does patient's insurance require a referral and/or authorization? YES / NO
   Referral number and/or copy of referral: _____
2. Referring office to circle tests completed and FAX results:
   X-ray; Bone Scan; MRI; MRA; EMG/NCS; CT; Surgery; Other: _____

BAY REGION ORTHOPEDIC USE ONLY

Appointment Date: _____ Time: _____
Patient Notification: Date: _____ Initials: _____ Time: _____
Referring Provider Notified: Date: _____ Initials: _____ Time: _____
New Patient packet mailed on: Date: _____ Initials: _____ Time: _____
Insurance Verified: Yes _____ No _____ Initials: _____ Time: _____

REFERRAL USE ONLY